

2017-03

# Concerns about care and communication are key causes of moral distress in intensive care staff.

Coombs, MA

<http://hdl.handle.net/10026.1/13045>

---

10.1016/j.aucc.2017.01.007

Aust Crit Care

---

*All content in PEARL is protected by copyright law. Author manuscripts are made available in accordance with publisher policies. Please cite only the published version using the details provided on the item record or document. In the absence of an open licence (e.g. Creative Commons), permissions for further reuse of content should be sought from the publisher or author.*

Coombs MA. 2017. Concerns about care and communication are key causes of moral distress in intensive care staff. Australian Critical Care March 2017 Volume 30, Issue 2, Pages 107–108

Author copy. Accepted for publication 22 January 2017

DOI: 10.1016/j.aucc.2017.01.007

## **Concerns about care and communication are key causes of moral distress in intensive care staff**

Coombs MA RN PhD Graduate School of Nursing, midwifery and Health Victoria University of Wellington New Zealand

Keywords Intensive Care Clinical teams Moral distress Qualitative research

### **Research article for critique**

Henrich NJ, Dodek PM, Alden L, Keenan SP, Reynolds S, Rodney P. Causes of moral distress in the intensive care unit: a qualitative study. Journal of Critical Care 2016; 3: 57-62.

#### **1. Objective**

To examine the causes and consequences of moral distress in members of the intensive care unit (ICU) team in community and tertiary ICUs.<sup>1</sup>

#### **2. Design and setting**

This was a qualitative study conducted using focus groups and telephone interviews with ICU doctors, ICU nurses and other ICU health professionals in two tertiary hospitals and one community hospital in the Vancouver area, Canada. The study was undertaken by a multi-disciplinary research team.

#### **3. Research process**

Focus groups and interviews were conducted in three hospital sites previously involved in a moral distress survey undertaken by the team.<sup>2</sup> Stratified sampling was carried out to ensure representation of discipline-specific focus groups in each site. Focus groups and interviews explored moral distress that resulted from conflicts in care and were conducted by an experienced health researcher. Focus groups and interviews were audio recorded and transcribed. NVivo9 facilitated data management and data analysis. Data were coded and themes developed to qualitatively describe the study findings. Data was also described quantitatively using attribution analysis.

#### **4. Findings**

Ten focus groups were held and four interviews conducted; a total of 56 intensive care staff participated in this study. At each hospital site, individual focus groups were conducted with registered nurses, physicians, and other health professionals. An additional focus group was held with clinical nurse leaders in one site, and four interviews (three nurses, one other health

professional) were undertaken. Eight causes of moral distress were identified and broadly described as: quality of care; amount of care provided; inconsistent care plans; poor communication; end-of-life decision making; interaction and conflict with families; recommendations for patient care ignored; lack of support and resources. The most frequently cited concerns were about care provided by other health care workers, the amount of care provided (especially too much care at end of life), and poor communication. There was some variation in response across intensive care disciplines, for example, nurses specifically spoke of inconsistency in care planning, and other health professionals raised end-of-life decision making as a cause of concern. Some site-specific responses were noted, specifically concern by physicians and other health professionals in the community hospital site about possible early withdrawal of life-sustaining treatment in patients.

## 5. Conclusion

Concerns about quality and amount of care, communication about care provided, and the availability of support and resource available to staff were key issues causing moral distress in intensive care staff. There were some discipline-specific and site-specific factors that led to concern about care in staff. With lack of autonomy and control purported to be a principal factor in moral distress, specific low-cost within-ICU changes could address some causes of moral distress in intensive care.

## 6. Critique

With increased understanding of the consequences of moral distress on health care staff<sup>2</sup> and recognition that intensive care staff are at high risk of moral distress,<sup>3</sup> further research in this area is always welcomed. As such, the paper by Henrich et al.<sup>1</sup> offers perspectives that both confirm and extend what we know about moral distress in intensive care settings, and across ICU disciplines. In drawing attention to concerns about care and communication, it supports similar health care work undertaken in Australasia<sup>4,5</sup> and in intensive care settings worldwide.<sup>6,7</sup> Furthermore, in offering a multi-disciplinary perspective on moral distress, this study addresses a recognised limitation in this research area.<sup>8</sup>

To assist readers assess the rigour of this qualitative study, the authors give detail about many aspects of the study and study design including reference to previous survey work, and access to Supplemental Digital Content. There is also information about the development and support of the researcher, an area often lacking when reporting studies. In offering critical commentary on this paper, there are three specific methodological areas requiring review: study coherence; auditability of the research; and the nature of the recommendations made.

Study coherence concerns whether a study achieves its stated purpose; whether it uses methods that are aligned with espoused theories and paradigms; and whether the literature, research aim, methods, and findings all interrelate.<sup>9</sup> Whilst the literature, paradigms, methods and findings in the paper are aligned, it is less clear as to whether the study achieved its stated purpose. For example, the causes of moral distress are described, but the consequences are not clearly articulated. The sampling approach supports the study aim of exploring moral distress in diverse team members across community and tertiary sites, but these are not well explored. There is some description of the sites in the paper and supplemental digital content, but specific detail of is lacking. This would have been useful for readers to make judgement about the transferability of findings to their own

setting. Similarly, it would have been informative to see a more in-depth discussion in study findings and discussion sections about the similarities and differences across team members, and across settings. For example, quantitative reporting on attribution analysis per site could have supported this, as could greater discussion about moral distress reported by physicians and other health professionals in the community hospital site about early withdrawal of life-sustaining treatment. For qualitative research to be of high quality, it must be rigorous. Auditability is one criteria to determine qualitative research rigour.<sup>10</sup> Auditability can be assessed through the clear and transparent description of the research process including how raw data are organised and analysed. In the paper, there is information about how thematic and attribution analysis was developed, and the research quality checking processes. However, use of attribution analysis undertaken on the findings raised some interesting questions. There has been little published about attribution analysis, a form of content analysis using quantitative description to make judgements about data importance,<sup>11</sup> since the 1960's. Quantifying data in thematic analysis is unusual and, given that only sub-themes were quantified in this paper, this approach would have benefitted from further methodological justification and discussion. Given the impact of moral distress on the provision of safe patient care and retention of health care staff, understanding what elicits moral distress is important. As Henrich et al.<sup>1</sup> identify, this can help tailor specific interventions to address causative factors and indeed, practical recommendations are made by the authors to address the 'more easily modifiable causes' of moral distress. However, it is less clear how some of these recommendations can minimise moral distress, or how these address the lack of autonomy and control experienced by intensive care staff when caring for critically ill patients. That said, this paper clearly highlights how changing unit culture to reduce moral distress continues to be a significant challenge for intensive care teams, and across settings.

## REFERENCES

1. Henrich NJ, Dodek PM, Alden L, Keenan SP, Reynolds S, Rodney P. Causes of moral distress in the intensive care unit: a qualitative study. *Journal of Critical Care* 2016; 3: 57-62.
2. Pauly, BM, Varcoe C, Storch J. Framing the Issues: Moral Distress in Health Care. *HealthCare Ethics Committee Forum* 2012; 24: 1. doi:10.1007/s10730-012-9176-y
3. Whitehead PB, Herbertson MS, Hamic AB, Epstein EG, Fisher JM. Moral Distress Among Healthcare Professionals: Report of an Institution-Wide Survey. *Journal of Nursing Scholarship*. 2015; 47: 117–125. DOI: 10.1111/jnu.12115
4. Johnstone MJ. Moral distress. *Australian Nursing Journal* 2013; 21: 25.
5. Woods M, Rodgers V, Towers A, La Grow S. Researching moral distress among New Zealand nurses: A national survey. *Nursing Ethics* 2014; 22:117-30. doi: 10.1177/0969733014542679
6. St Ledger U, Begley A, Reid J, Prior L, McAuley D, Blackwood B. Moral distress in end-of-life care in the intensive care unit. *Journal of Advanced Nursing* 2013; 69: 1869-80. doi: 10.1111/jan.12053.
7. Karanikola MN1, Albarran JW, Drigo E, Giannakopoulou M, Kalafati M, Mpouzika M, Tsiaousis GZ, Papathanassoglou ED. Moral distress, autonomy and nurse-physician collaboration among intensive care unit nurses in Italy. *Journal of Nursing Management* 2014; 22: 472-84. doi: 10.1111/jonm.12046.

8. Prentice T, Janvier A, Gillam L, Davis PG. Moral distress within neonatal and paediatric intensive care units: a systematic review. *Archives of Diseases in Childhood* 2016;101:701–708. doi:10.1136/archdischild-2015-309410
9. Tracy SJ. Qualitative Quality: Eight "Big-Tent" Criteria for Excellent Qualitative Research. *Qualitative Inquiry* 2010 16: 837-851. DOI. 10.1177/1077800410383121
10. Noble H, Smith J. Issues of validity and reliability in qualitative research. *Evidence Based Nursing* 2015;18:34-35 doi:10.1136/eb-2015-102054
11. Janis IL. The problem of validating content analysis. In 'Language of Politics'. p.55-82. Lasswell HD, Leites N. and Associates (eds.). 1965. MIT Press, Cambridge.